Dental Land
3514 Burke Rd Suite 100
Pasadena, TX 77504

HIPAA ACKNOWLEDGMENT CONSENT TO DISCLOSE PRIVATE HEALTHCARE INFORMATION FOR TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS

TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations. **For example: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you**; **we may use and disclose your health information to obtain payment for services we provide to you.** A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Office Manager
Email: Dentalland13@yahoo.com
Address: 3514 Burke Rd, Suite 100
Pasadena, TX 77504
Telephone: (832) 831-2301
Fax: (832) 831-2309

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time.

_____ Yes, I give my consent to have my information released as indicated above.

_____ No, I do not give my consent to have my information released as indicated above.

Printed Name:_____ Date:_____

Patient

Signature:_____ Date:_____

Signature Patient/Parent or Guardian of minor child

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AGREEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature_____

Date_____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

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